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Submitted Electronically

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Office of the Secretary
Federal Communications Commission
445 12th Street SW
Washington DC 20554

Re: Rural Health Care Support Mechanism WC Docket 02-60

Midwest Networks is an telecommunications engineering and consulting company involved with the USF on an ongoing basis for Health Care Providers (HCP) in the great lakes region. The comments contained in this response to the proposed rule making are based on our experiences and feedback from our clients on the program and also limited feedback from carriers.

It's important to note; the reason carrier(s) want to be involved in the program is to sell more lines, circuits, or features. The USF allows an HCP to cost effectively upgrade services, install new services, and expand applications because of the support.

The providers are interested in a less time consuming method to get more support with fewer restrictions so they can get on with their primary function, assisting patients in rural areas.

1-Create a Standard Urban Rate (SUR) and Eliminate Form 468

The concept of a level playing field for Rural Health Care Providers (hospitals, clinics, etc.) is a simple expansion of the existing FCC programs to allow the economic benefits of competition in the urban areas to be passed on to rural regions in the county. To make the program work, requires the Rural Health Care Providers to understand the competitive market in the nearest urban area over 50,000 people as it pertains to telecommunication services. As an alternative to direct information, the Rural Health Care Providers rely significantly on the information provided by the carrier(s). Depending on the knowledge of the carrier(s) depth of knowledge and experience, the information concerning urban rates can vary in accuracy over the entire spectrum from wrong to somewhat correct to right on "the money."

The RHCP may not understand how to calculate support or be aware of the maximum amount that would be allowed per service. Yet, the RHCP is eventually the sole entity that carries the burden of proof for defending the support amount and methods utilized in their calculation. Therefore, carrier(s) that have secured the "business" may provide conservative numbers that are easy to justify the support amounts or use incorrect assumptions.

The RHCP is in no position to argue. The carrier(s) provide the 468 forms with the urban versus rural rates that must be entered onto the HCP 466 Form "exactly" as indicated from the carrier.

Create a Standard Urban Rate (SUR) on a per state basis that would provide a standard deduction for each Telecommunication Service (TS): Point to Point T-1, Local ISDN-PRI,

Centrex, Multi-Point 56kbps, Frame Relay, etc. The SUR would be the mean average for the service based on a total of all urban rate centers in the state.

Each Telecommunication Service (TS) would have a corresponding Standard Urban Rate (SUR) that would be entered on form 466. The SUR would at a minimum give an idea of the magnitude of the support available on a Service by Service basis. The HCP would be allowed to provide additional documentation establishing lower competitive rates for support for requested services.

This modification will speed and simplify the funding calculations for supported services, eliminate the need for Form 468, and increase support amounts requested and authorized per service.

2-Direct Funding of HCP from the RHCD

The current process has the carrier acting as paymaster for the program. Delays in funding, shortages, and simple accounting errors require extensive staff time from the RHCD, HCP and carrier to correct these problems or answer simple questions.

Direct funding by the RHCD to the HCP would simplify the process, saving time to track down misapplications or funds being delayed for release by the carrier. The carriers would benefit the most in reduced paperwork for funding. The RHCD and the HCP would see faster resolution of funding complaints or questions.

3-Increase the Maximum Allowable Distance for HCP applications

The standard to determine the maximum amount of mileage support is based on the rural facilities being networked into the nearest large (50k+ people) city. Rural health care networks often flow to the largest city in the state or often are linked to the state supported medical colleges, or government centers where the resident experts are located.

With 9-11 and the Health Information Privacy and Accountability Act (HIPAA), networks must be designed to provide security and survivability plus be simple to manage and reconfigure in an emergency situation. These requirements and others may force the service to be extended beyond the Maximum Allowable Distance (MAD) to centralized operation center hub locations or switching centers. Information networks do not follow line of sight but are designed to meet the critical requires of health care.

The HCP would pay for the initial SUD equivalent. If the MAD is eliminated and support is increased, the HCP continues to have a financial incentive not to waste their SUD portion.

By eliminating calculation the MAD and using Standard Urban Rates (SUR) for the urban rate comparisons, the RHCD will save staff time in determining which is the "Nearest Large City" and extensive calculations and review when the MAD is exceeded. The MAD should be expanded to include the maximum distance from any city to any city in each state.

4-Maintain and Enhance the 28 Day Posting by Identifying Services Required

Posting and the effort associated with being able to communicate to the carrier what services are required is crucial in saving money, accountability, deterring fraud, and waste in general.

Competition is coming and slowly and the HCP will not realize the competitive options unless posting for all services is required. If the MAD is expanded to include the entire state, long haul circuits will attract more competition from the urban areas. CLEC, ILEC, and others will want to provide all or a portion of the network. The carriers have a right, the FCC has an obligation, and the HCP has a duty to provide a level playing field for the carriers. This must include a detailed listing of services required.

The existing system is open to waste and abuse. The HCP can fail to respond to requests for what service(s) are required when carriers respond. An initial request for a 56kbps line can suddenly become during the posting time frame or after (way after) a T-1 circuit. Should the carrier be required to call everyday for an update? What if the HCP never responds with specific requirements?

Every Posting should contain a link to detail the specific requirements of the services requested to be supported both contract and non-contract. This will require the HCP to identify the services they want bids for: T-1 ESF/B8ZS Pt to Pt, from 201-222 to 202-222, Centrex Service 24 lines 201-222, etc.

The carriers would respond via E-mail to the RHCD site. The RHDC would keep a copy of the service offer on file and send a copy to the 465 contact persons E-mail. This would assist in determining if the process is working as designed and be able to monitor interest in the program based on the responses from the carriers. The HCP may be required to prod their local telco directly to advise them of the requirement and have the local telco to respond with a bid.

This simple addition by requiring the HCP to determine and post their communication needs prior to posting, would improve competition. Using the RHCD web site as a bulletin board would expand awareness of the services and types of services needed plus allow extensive review of the quality and quantity of responses.

5- Maintain the Current Eligible Health Care Providers

The seven categories are sufficient. The inclusion of nursing homes, hospices, long-term care facilities, and emergency medical services should not be included in the program. The support is to provide for rural hospitals and clinics to use technology to care for patients in the rural areas. Providing support to retirement centers in rural areas should not be allowed. There are other funding mechanisms to allow local or state money to help in these areas.

If there is a need for a communication link to a hospice, nursing home, or EMS, an eligible HCP should be responsible to provide the health service connection. Nursing homes, hospice, long-term care facilities should partner with an HCP, not be give a blank check to have support for any or all services.

6-Enhance Dedicated Internet Access and Satellite Service

To meet the needs of the patient, provide timely information on health related situations, and transfer of information quickly and effectively requires a dedicated connection. Urban areas tend to have access to ISPs via ISDN-BRI, dedicated T-1, DSL, frame relay, and cable modems. The cost per 100kbps average in the range of \$45 per month. Rural areas limited to only a few of these options because of a smaller market for services, 100kbps averages in the range of \$125 per month. Satellite access, which is generally universal, is also in the range of \$125 per month.

To maintain an effective network connection from the HCP, the USF should provide funding to the HCP up to \$80 per month to allow access via ISP at a rate of 100kbps for supporting information transfer requirements.

7-Functionality Should Not be used for Support Calculations

It makes perfect sense, to compare the same or very similar facility/service to determine the amount of support based on the difference in price between the urban and rural areas. This approach for all transport services is very simple and easy to understand.

When the rural area doesn't have available a similar service as the urban area, can we randomly select any service for comparison?

If we try to extend this concept into functionality, the underlying transport is inconsequential for the application. Sending data could be done using a T-1, DSL, or cable modem in the urban setting. The rural setting only offers T-1. Should the support be based on cable modem (urban) versus T-1 (rural)?

T-1 is a premium service: 1.544 Mbps, 99.99% availability, loopback and amplifier on customer premise, ability to test from the Central Office, and highly secure.

DSL or unloaded copper pairs originate at the Central Office and can reach only 4 cable miles at 256kbps and is far inferior service without the ability to provide comprehensive testing, provide high availability, maintain high bandwidth, and security. Cable modems provide high bandwidth but suffer from the same limitations for testing, availability and security.

HCP should not be able to select any service for comparison purposes just for the sake of increasing the amount of support. Allowing this type of support calculation would introduce extensive staff time in establishing guidelines for functional comparisons.

8-Allow NEW HCP to Maintain Existing Contracts

Requesting support can cost the HCP money! A hospital that is new to the program (they were unaware of the USF-RHC program and implications of signing a contract) and signed a 5-year contract 3 years ago. The HCP used their best judgment and secured the best facility for the best cost and selected a multi-year contract to maximize their discount.

Now, the HCP faces a potential termination liability if they post, cancel the existing service, and install a new service. If they're lucky, they may avoid the penalty but have to sign an extension, which locks their rate for the next 5 years.

For an HCP posting for the first time, allow them the option of maintaining the same contract if there are no competitors for the business or lower rate per month based on their current contract.

Having to lock into another 5 years when it's not absolutely necessary reduces the opportunity to save in coming years as competition reaches rural areas.

9-Grandfather the current status of HCPs

Grandfather existing HCP locations regardless of their status based on the Office of Rural Health Policy modifications based on the 2000 census. This step would help to minimize the impact of a recent HCP suddenly being refused support for newly installed (and contracted) circuits.

Sincerely,

Michael O'Connor PE
Manager Health Services Support